



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION ANCILLARY SVCS AFFILIATES, LLC
5240 WEST LOOP SOUTH SUITE 3100
BELLAIRE TEXAS 77401

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LM INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-3238-01

MFDR Date Received

May 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since Liberty Mutual is stating these codes are 'Bundled' according to Medicare I have enclosed a copy of Medicare's 2011 Fee Schedule Indicators. All the codes our office renders do not and I quote 'Does not have the indicator of 'B (bundled)' (according to Medicare) listed beside the code(s).' Therefore, Liberty Mutual has failed to properly review the documentation that they are using as supporting evidence to deny a provider of service claims. All the procedure codes we primarily use 95920, 95925, 95926, 95929, 95955, 95957, 95861, 51785 and 95900 do not have the Bundling Indicator. Please note according to the National Coding and AMA, these codes are separately billable for the Technical and Professional Component and these codes are separately reimbursable."

Amount in Dispute: \$536.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and an adjustment has been made to allow for the following: CPT code 95925 as this is not payable per Medicare Local Coverage determination –Neurophysiological Studies – 4F-71 AB-R3 as updated Revision Date: 1/1/2011. Provider billed ICD-9 722.10 which is not covered per this Medicare LCD." CPT 95861 (Needle Electromyography; 2 extremities with or without related paraspinal areas) was denied because the submitted narrative report suggest only surface EMG performed.

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2011	95920, 95925 and 95861	\$536.53	\$509.67

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, sets out the fee guidelines for professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- X003 – The charge for this procedure, material, and or services is not normally billed. For Texas jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 Tex. Admin. Code sections 133.308 (H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC-Appointment independent review organization. The form to initiate this process can be obtained from the division website at www.tdi.state.tx.us and must be sent via fax...
- B291 – This is a bundled or non covered procedure based on Medicare Guidelines; no separate payment allowed.

Issues

1. Did the requestor bill in conflict with NCCI edits?
2. Did the requestor submit documentation to support that the services were rendered as billed?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 states in pertinent part, “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
 - NCCI edits were run to identify if the disputed charges contain edit conflicts.
 - The requestor billed the following CPT codes on 95920-TC-59, 95925-TC, 95926-TC, 95861-TC-59, 99080, A4556, and A4557.
 - No NCCI edits were identified for CPT code 95920, 95925 and 95861. Therefore the disputed charges will be reviewed according to the applicable guidelines.
2. Per 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32 (2)... Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...”
 - The Medicare reimbursement amount for CPT code 95920-TC is \$48.70. With the division established conversion factor the fee guideline reimbursement amount is \$78.17/unit. The requestor billed and documented 3 units, therefore reimbursement is recommended in the amount of \$234.52.
 - The Medicare reimbursement amount for CPT code 95925-TC is \$122.39. With the division established conversion factor the fee guideline reimbursement amount is \$196.46, this amount is recommended.
 - The Medicare reimbursement amount for CPT code 95861-TC is \$49.02. With the division established conversion factor the fee guideline reimbursement amount is \$78.69, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$509.67.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$509.67 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 12, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.